



IZINDABA

her husband Mendi (ANC Treasurer-General and former South African Ambassador to Britain) separately at informal occasions.'

'When you get beyond the HIV/AIDS line, she is a lovely person; I call him 'Bra Mendi' and her 'Aunty,' he revealed.

Mogari attended the same medical school with Gwen Ramakgoba (Gauteng Health MEC) and Molefi Sefularo (North West Health MEC) and has 'good relationships' with them.

While SAMA would continue to highlight legislative issues affecting doctors, 'we are committed to become an integral part of the health care delivery system in partnership with the government'.

He said SAMA's actions should 'not be viewed in a negative light, but as a way of highlighting the issues to a public that is not fully informed'.

If a feature of Letlape's chairmanship has been to play 'bad cop' to the government's recalcitrance around health issues, Mogari seems well set to play the 'good cop'.

Mogari, who completed a Wits Business School certificate programme in finance and accounting *cum laude* emphasised that the current problems extended 'well beyond government' into the private sector and health care funding.

Yet one of his first tests will be enrolling government into using GPs (who see over 50% of South Africa's patients) as a vital platform for dispensing antiretroviral drugs — reliably learnt to be a key recommendation of the cabinet AIDS task team.

Whether the new 'good cop, bad cop' team can pull that one off in the face of 'sloppy' new dispensing legislation disadvantaging both patients and doctors, remains to be seen.

Chris Bateman

DRUG PRICING: THE END OF THE GRAVY TRAIN?

South Africa's new drug pricing committee, committed to 'dramatically' slashing overall drug prices and putting quality medicines within reach of many more people, is under considerable time pressure to complete the most difficult and contentious chunk of its work.

Section 18A of the Medicines Control Amendment Act, which prevents anyone from supplying medicine via a bonus system, rebate system or any other incentive scheme, is due for implementation on 2 May 2004.

According to the committee chairperson, health economist Diane McIntyre, some stakeholders feel that it would be best if regulations arising from the pricing committee's recommendations came into effect at the same time as Section 18A.

McIntyre emphasised that it was 'crucial' for all those involved in the manufacture, distribution and dispensing of medicines to recognise that Section 18A is not part of the pricing committee's terms of reference and that it will come into effect on 2 May 2004 in terms of the 'Presidential proclamation on this Act'.

'We're under pressure to come up with proposals and to have something in place by the time this section kicks in. Everyone agrees that the time frame is short. But the bottom line is we'll pull out all the stops to try to meet the deadline.'

She did, however, say that she would refuse to compromise if her committee felt they were not in a position to put forward sound and solid recommendations.

'If we can't defend and argue strongly for our recommendations, we'll not consider ourselves bound by this time frame — at the end of the day we want our recommendations to be based on good information.'

The pricing committee's functions include:

- The introduction of a transparent pricing system, including a single exit price for all medicines and scheduled substances.
- Determination of an appropriate dispensing fee to be charged by pharmacists or any person licensed to dispense in terms of the Act.

- Determination of an appropriate fee to be charged by the wholesalers or distributors or any person selling medicines that do not require prescription.

At the time of the SAMJ interview (17 September) McIntyre indicated that she was busy trying to establish from the Ministry of Health when the representatives from the Treasury and Trade and Industry would be appointed to her committee.

She said these members needed to be on board before the committee could come up with its recommendations.

'I'm confident that it will happen quite quickly because everyone regards this work as really important and urgent. In the meantime we can collect information and start doing some thinking.' She said all committee members were appointed on the basis of technical expertise.

She appealed to doctors 'to understand that it's going to be difficult to have detailed consultations with people before we put together our draft recommendations'. As evidence of the



bona fides of her committee, McIntyre pointed to information-gathering 'legwork' done by a pricing committee working group that took detailed inputs from a range of stakeholders at the end of last year.

'We have a clear picture of who the key players are, how it works and what people's thinking is around this initiative.'

She made an appeal for all further inputs to be 'brief and in writing', saying the sooner they reached her, the more likely it was that they would impact on the draft recommendations.

On dispensing fees, the subject of much rumour and conjecture among doctors, McIntyre said the legislation made no mention of a 'flat rate'.

'Some argue that it should be a percentage value of the drugs and others say a flat professional fee — this is all stuff we will probe. What has to be realised is that the ultimate purpose and guiding light of the pricing committee is that the price of medicines in the private sector is too high and one needs to bring it down.'

She saw her task as 'interrogating every aspect' contributing to the high price of medicines.

'At the end of the day there will be downward pressure all along the chain.'

One of the greatest difficulties facing the committee was the lack of information and transparency — key elements of its terms of reference.

'It's become just about impossible to work out what's legitimate and what's gravy-train,' she observed.

McIntyre said pharmaceutical members of her committee would 'disagree strongly' with suggestions that the seasoned drug industry would succeed in pulling the wool over their eyes.

'We have plenty of people who know exactly how it works and they have high skills levels.'

She refused to speculate on how much cheaper the person on the street would find medicines once recommendations were adopted, but said South Africa was out of kilter with international pricing, with some local products selling for 120% above the manufacturer price.

The differences between branded and generic prices were also far greater overseas, she said, citing Brazil where the price gap was a 70% difference versus a '10 - 20% difference here'.

'If we can't defend and argue strongly for our recommendations, we'll not consider ourselves bound by this time frame — at the end of the day we want our recommendations to be based on good information.'

'The extent to which the price of drugs to consumers declines is also linked to generic substitution. You could say prices will come down by half, but that will depend on how well we can interrogate the manufacturer price and pressure that down to be more in line with international figures. It's also about how well we can come up with distribution and dispensing fees that adequately compensate for a professional service but on the other hand are not excessive.'

Public acceptance of generic substitution was another big factor in the ultimate pricing.

McIntyre believes her committee's ultimate purpose is 'very much in line with what doctors want for their patients'.

'Patients need to access treatment when they need it without jeopardising their livelihoods — often people have to borrow money to be able to buy medicines or even buy less medicine than they actually need,' she stressed.

'I can't tell you how many people have said things like they had to stop

taking medicine for chronic depression because their medical scheme benefit ran out.'

The youngest, eldest and poorest were hardest hit, particularly those in rural areas who did not have public health sector access.

'They can't afford to queue at a clinic or hospital for hours, so they turn to private care — financially it's really difficult.'

McIntyre said she personally found the *de facto* situation 'unacceptable — these kind of things really worry me, especially when it comes to chronic medicines'.

She said her committee would obviously include AIDS-related drugs in their focus, but would take its lead from the antiretroviral (ARV) roll-out task team and assist on specifics if requested.

'There's so much time pressure to get the overall pricing system in place.'

A related development is the release of preliminary results of research into the cost of adult ARV treatment done by the Health Economics Unit and the Public Health Department (both at UCT), and Medecins Sans Frontieres, which show it to be highly effective when compared with the costs of treating AIDS-related opportunistic diseases.

The incremental cost of ART was shown to be R8 765 per life year gained and its incremental effectiveness was 6.04 life years gained.

Chris Bateman